QUICK QUOTE FOR SLEEP APNEA

Provada ill be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.

CLIENT: NAME Robin Lee Powell ☒ M ☐ F / DOB 8 Dec 1975 AGE 35 / HT 6'0" WT 205 / STATE CA

AMT. REQUESTED $ 500,000 / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS. ☐ UL ☒ TERM YRS. LVL _____

TOBACCO USE ☒ NO ☐ YES, TYPE _____ / REPLACEMENT ☐ YES ☐ NO / CURRENT ANN. PREM. $ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION Systems Administrator / MARITAL STATUS ☒ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

FAMILY HISTORY - AGE, IF STILL LIVING: FATHER _____ MOTHER 65 SIBLING 1 42 SIBLING 2 29 SIBLING 3 _____

IF ANY DECEASED GIVE RELATION, AGE AND CAUSE, OF EACH Father, natural causes, 75

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS 0 / # OF DUI / RECKLESS DRIVING PAST 5 YEARS 0

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? ☒ NO ☐ YES, DETAILS _____

DATE OF LAST MEDICAL CHECKUP Mid 2011 DATE OF LAST EKG Mar 2008 AND RESULTS Normal

LAST BLOOD PRESSURE READING (RESULTS) 118 / 74 / ARE YOU TREATED FOR BLOOD PRESSURE ☒ NO ☐ YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) 111 ldl, 44 hdl TREATED FOR CHOLESTEROL ☐ NO ☒ YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

1. PLEASE GIVE DATE OF DIAGNOSIS 2002

2. PLEASE NOTE TYPE DIAGNOSED:

☒ OBSTRUCTIVE
☐ CENTRAL
☐ MIXED

3. HAS A SLEEP STUDY, OR STUDIES, BEEN COMPLETED?

☒ YES ☐ NO, IF YES, PLEASE NOTE DATE(S) OF STUDY(IES):

FIRST STUDY 2002 LAST STUDY no others

AND NOTE THE FOLLOWING:

OXYGEN SATURATION LEVEL Don't know

APNEA INDEX (AI) OR RESPIRATORY DISTURBANCE INDEX (RDI) RESULTS:

>100 (NUMERIC VALUE)

4. WHAT TREATMENT HAS BEEN PRESCRIBED (PLEASE CHECK ALL THAT APPLY):

☐ OBSERVATION ALONE
☐ WEIGHT LOSS ALONE
☐ CPAP MASK (IF CHECKED, DATE LAST USED) _____
☒ SURGERY (TRACHEOTOMY OR UVULOPALATOPHARYNGOPLASTY)
☐ MEDICATION (PLEASE DETAIL TYPE AND DOSAGE):

_____

5. ARE THERE ANY CURRENT SYMTOMS?

☒ NO ☐ YES, DETAILS Some apnea if I sleep on my back only.

6. HAS THE CLIENT EXPERIENCED ANY OF THE FOLLOWING ILLNESSES (CHECK ALL THAT APPLY AND GIVE DETAILS):

☐ ARRHYTHMIA, TYPE _____

☒ OTHER HEART RELATED CONDITION, TYPE See attached

☐ ASTHMA, COPD OR EMPHYSEMA, TYPE _____

☐ DEPRESSION

☐ OVERWEIGHT, PLEASE CONFIRM HT _____ WT _____

7. HAS THE CLIENT SMOKED CIGARETTES IN THE PAST 12 MONTHS?

☐ NO ☐ YES, PLEASE DETAIL AMOUNT PER DAY AND DATE STOPPED, IF NO LONGER SMOKING:

_____

8. LIST ANY OTHER ILLNESSES OR IMPAIREMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY:

_____

_____